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SENATE BILL 743

46TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2003

INTRODUCED BY

Timothy Z. Jennings

AN ACT

RELATING TO INSURANCE; PROVIDING COVERAGE FOR SMOKING  
PREVENTION AND CESSATION TREATMENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. A new section of the New Mexico Insurance  
Code, Section 59A-22-44 NMSA 1978, is enacted to read:

"59A-22-44. [NEW MATERIAL] COVERAGE FOR SMOKING  
PREVENTION AND CESSATION TREATMENT. --

A. An individual or group health insurance policy,  
health care plan or certificate of health insurance that is  
delivered or issued for delivery in this state and that offers  
maternity benefits shall offer coverage for smoking prevention  
and cessation treatment.

B. Coverage for smoking prevention and cessation  
treatment may be subject to deductibles and coinsurance

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1 consistent with those imposed on other benefits under the same  
2 policy, plan or certificate.

3 C. The provisions of this section shall not apply  
4 to short-term travel, accident-only or limited or specified-  
5 disease policies. "

6 Section 2. Section 59A-23-4 NMSA 1978 (being Laws 1984,  
7 Chapter 127, Section 463, as amended by Laws 1997, Chapter 7,  
8 Section 2 and by Laws 1997, Chapter 249, Section 2 and by Laws  
9 1997, Chapter 250, Section 2 and also by Laws 1997, Chapter  
10 255, Section 2) is amended to read:

11 "59A-23-4. OTHER PROVISIONS APPLICABLE. --

12 A. ~~[No]~~ A blanket or group health insurance policy  
13 or contract shall not contain ~~[any]~~ a provision relative to  
14 notice or proof of loss or the time for paying benefits or the  
15 time within which suit may be brought upon the policy that in  
16 the superintendent's opinion is less favorable to the insured  
17 than would be permitted in the required or optional provisions  
18 for individual health insurance policies as set forth in  
19 Chapter 59A, Article 22 NMSA 1978.

20 B. The following provisions of Chapter 59A, Article  
21 22 NMSA 1978 shall also apply as to Chapter 59A, Article 23  
22 NMSA 1978 and blanket and group health insurance contracts:

23 (1) Section 59A-22-1 NMSA 1978, except  
24 Subsection C of that section; and

25 (2) Section 59A-22-32 NMSA 1978.

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1 C. The following provisions of Chapter 59A, Article  
2 22 NMSA 1978 shall also apply as to group health insurance  
3 contracts:

- 4 (1) Section 59A-22-33 NMSA 1978;  
5 (2) Section 59A-22-34 NMSA 1978;  
6 (3) Section 59A-22-34.1 NMSA 1978;  
7 (4) Section 59A-22-34.3 NMSA 1978;  
8 [~~(4)~~] (5) Section 59A-22-35 NMSA 1978;  
9 [~~(5)~~] (6) Section 59A-22-36 NMSA 1978;  
10 [~~(6)~~] (7) Section 59A-22-39 NMSA 1978;  
11 (8) Section 59A-22-39.1 NMSA 1978;  
12 [~~(7)~~] (9) Section 59A-22-40 NMSA 1978; [and  
13 ~~(8)~~] (10) Section 59A-22-41 NMSA 1978;  
14 (11) Section 59A-22-42 NMSA 1978; and  
15 (12) Section 59A-22-44 NMSA 1978. "

16 Section 3. Section 59A-23B-3 NMSA 1978 (being Laws 1991,  
17 Chapter 111, Section 3, as amended by Laws 1997, Chapter 249,  
18 Section 3 and also by Laws 1997, Chapter 250, Section 3) is  
19 amended to read:

20 "59A-23B-3. POLICY OR PLAN--DEFINITION--CRITERIA. --

21 A. For purposes of the Minimum Healthcare  
22 Protection Act, "policy or plan" means a healthcare benefit  
23 policy or healthcare benefit plan that the insurer, fraternal  
24 benefit society, health maintenance organization or nonprofit  
25 healthcare plan chooses to offer to individuals, families or

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1 groups of fewer than twenty members formed for purposes other  
2 than obtaining insurance coverage and that meets the  
3 requirements of Subsection B of this section. For purposes of  
4 the Minimum Healthcare Protection Act, "policy or plan" shall  
5 not mean a healthcare policy or healthcare benefit plan that an  
6 insurer, health maintenance organization, fraternal benefit  
7 society or nonprofit healthcare plan chooses to offer outside  
8 the authority of the Minimum Healthcare Protection Act.

9 B. A policy or plan shall meet the following  
10 criteria:

11 (1) the individual, family or group obtaining  
12 coverage under the policy or plan has been without healthcare  
13 insurance, a health services plan or employer-sponsored  
14 healthcare coverage for the six-month period immediately  
15 preceding the effective date of its coverage under a policy or  
16 plan, provided that the six-month period shall not apply to:

17 (a) a group that has been in existence  
18 for less than six months and has been without healthcare  
19 coverage since the formation of the group;

20 (b) an employee whose healthcare  
21 coverage has been terminated by an employer;

22 (c) a dependent who no longer qualifies  
23 as a dependent under the terms of the contract; or

24 (d) an individual and an individual's  
25 dependents who no longer have healthcare coverage as a result

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1 of termination or change in employment of the individual or by  
2 reason of death of a spouse or dissolution of a marriage,  
3 notwithstanding rights the individual or individual's  
4 dependents may have to continue healthcare coverage on a self-  
5 pay basis pursuant to the provisions of the federal  
6 Consolidated Omnibus Budget Reconciliation Act of 1985;

7 (2) the policy or plan includes the following  
8 managed care provisions to control costs:

9 (a) an exclusion for services that are  
10 not medically necessary or are not covered by preventive health  
11 services; and

12 (b) a procedure for preauthorization of  
13 elective hospital admissions by the insurer, fraternal benefit  
14 society, health maintenance organization or nonprofit  
15 healthcare plan; and

16 (3) subject to a maximum limit on the cost of  
17 healthcare services covered in any calendar year of not less  
18 than fifty thousand dollars (\$50,000), the policy or plan  
19 provides the following minimum healthcare services to covered  
20 individuals:

21 (a) inpatient hospitalization coverage  
22 or home care coverage in lieu of hospitalization or a  
23 combination of both, not to exceed twenty-five days of coverage  
24 inclusive of any deductibles, co-payments or co-insurance;  
25 provided that a period of inpatient hospitalization coverage

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1 shall precede any home care coverage;

2 (b) prenatal care, including a minimum  
3 of one prenatal office visit per month during the first two  
4 trimesters of pregnancy, two office visits per month during the  
5 seventh and eighth months of pregnancy and one office visit per  
6 week during the ninth month and until term; provided that  
7 coverage for each office visit shall also include prenatal  
8 counseling and education and necessary and appropriate  
9 screening, including history, physical examination and the  
10 laboratory and diagnostic procedures deemed appropriate by the  
11 physician based upon recognized medical criteria for the risk  
12 group of which the patient is a member;

13 (c) obstetrical care, including  
14 physicians' and certified nurse midwives' services, delivery  
15 room and other medically necessary services directly associated  
16 with delivery;

17 (d) well-baby and well-child care,  
18 including periodic evaluation of a child's physical and  
19 emotional status, a history, a complete physical examination, a  
20 developmental assessment, anticipatory guidance, appropriate  
21 immunizations and laboratory tests in keeping with prevailing  
22 medical standards; provided that such evaluation and care shall  
23 be covered when performed at approximately the age intervals of  
24 birth, two weeks, two months, four months, six months, nine  
25 months, twelve months, fifteen months, eighteen months, two

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1 years, three years, four years, five years and six years;

2 (e) coverage for low-dose screening  
3 mammograms for determining the presence of breast cancer;  
4 provided that the mammogram coverage shall include one baseline  
5 mammogram for persons age thirty-five through thirty-nine  
6 years, one biennial mammogram for persons age forty through  
7 forty-nine years and one annual mammogram for persons age fifty  
8 years and over; and further provided that the mammogram  
9 coverage shall only be subject to deductibles and co-insurance  
10 requirements consistent with those imposed on other benefits  
11 under the same policy or plan;

12 (f) coverage for cytologic screening, to  
13 include a Papanicolaou test and pelvic exam for asymptomatic as  
14 well as symptomatic women;

15 (g) a basic level of primary and  
16 preventive care, including ~~[but not limited to]~~ no less than  
17 seven physician, nurse practitioner, nurse midwife or physician  
18 assistant office visits per calendar year, including any  
19 ancillary diagnostic or laboratory tests related to the office  
20 visit; ~~[and]~~

21 (h) coverage for childhood  
22 immunizations, in accordance with the current schedule of  
23 immunizations recommended by the American academy of  
24 pediatrics, including coverage for all medically necessary  
25 booster doses of all immunizing agents used in childhood

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1 immunizations; provided that coverage for childhood  
2 immunizations and necessary booster doses may be subject to  
3 deductibles and co-insurance consistent with those imposed on  
4 other benefits under the same policy or plan; and

5 (i) coverage for smoking prevention and  
6 cessation treatment.

7 C. A policy or plan may include the following  
8 managed care and cost control features to control costs:

9 (1) a panel of providers who have entered into  
10 written agreements with the insurer, fraternal benefit society,  
11 health maintenance organization or nonprofit healthcare plan to  
12 provide covered healthcare services at specified levels of  
13 reimbursement; provided that [~~any~~] such written agreement shall  
14 contain a provision relieving the individual, family or group  
15 covered by the policy or plan from [~~any~~] an obligation to pay  
16 for [~~any~~] a healthcare service performed by the provider that  
17 is determined by the insurer, fraternal benefit society, health  
18 maintenance organization or nonprofit healthcare plan not to be  
19 medically necessary;

20 (2) a requirement for obtaining a second  
21 opinion before elective surgery is performed;

22 (3) a procedure for utilization review by the  
23 insurer, fraternal benefit society, health maintenance  
24 organization or nonprofit healthcare plan; and

25 (4) a maximum limit on the cost of healthcare

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1 services covered in [~~any~~] a calendar year of not less than  
2 fifty thousand dollars (\$50,000).

3 D. Nothing contained in Subsection C of this  
4 section shall prohibit an insurer, fraternal benefit society,  
5 health maintenance organization or nonprofit healthcare plan  
6 from including in the policy or plan additional managed care  
7 and cost control provisions that the superintendent [~~of~~  
8 ~~insurance~~] determines to have the potential for controlling  
9 costs in a manner that does not cause discriminatory treatment  
10 of individuals, families or groups covered by the policy or  
11 plan.

12 E. Notwithstanding any other provisions of law, a  
13 policy or plan shall not exclude coverage for losses incurred  
14 for a preexisting condition more than six months from the  
15 effective date of coverage. The policy or plan shall not  
16 define a preexisting condition more restrictively than a  
17 condition for which medical advice was given or treatment  
18 recommended by or received from a physician within six months  
19 before the effective date of coverage.

20 F. [~~No~~] A medical group, independent practice  
21 association or health professional employed by or contracting  
22 with an insurer, fraternal benefit society, health maintenance  
23 organization or nonprofit healthcare plan shall not maintain  
24 [~~any~~] an action against [~~any~~] an insured person, family or  
25 group member for sums owed by an insurer, fraternal benefit

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1 society, health maintenance organization or nonprofit  
2 healthcare plan [~~for sums~~] that are higher than those agreed to  
3 pursuant to a policy or plan. "

4 Section 4. A new section of the Health Maintenance  
5 Organization Law is enacted to read:

6 "[NEW MATERIAL] COVERAGE FOR SMOKING PREVENTION AND  
7 CESSATION TREATMENT. --

8 A. An individual or group health maintenance  
9 organization contract that is delivered or issued for delivery  
10 in this state and that offers maternity benefits shall offer  
11 coverage for smoking prevention and cessation treatment.

12 B. Coverage for smoking prevention and cessation  
13 treatment may be subject to deductibles and coinsurance  
14 consistent with those imposed on other benefits under the same  
15 contract. "

16 Section 5. Section 59A-47-33 NMSA 1978 (being Laws 1984,  
17 Chapter 127, Section 879.32, as amended) is amended to read:

18 "59A-47-33. OTHER PROVISIONS APPLICABLE. -- The provisions  
19 of the Insurance Code other than Chapter 59A, Article 47 NMSA  
20 1978 shall not apply to health care plans except as expressly  
21 provided in the Insurance Code and that article. To the extent  
22 reasonable and not inconsistent with the provisions of that  
23 article, the following articles and provisions of the Insurance  
24 Code shall also apply to health care plans, their promoters,  
25 sponsors, directors, officers, employees, agents, solicitors

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1 and other representatives; and, for the purposes of such  
2 applicability, a health care plan may therein be referred to as  
3 an "insurer":

- 4 A. Chapter 59A, Article 1 NMSA 1978;
- 5 B. Chapter 59A, Article 2 NMSA 1978;
- 6 C. Chapter 59A, Article 4 NMSA 1978;
- 7 D. Subsection C of Section 59A-5-22 NMSA 1978;
- 8 E. Sections 59A-6-2 through 59A-6-4 and  
9 59A-6-6 NMSA 1978;
- 10 F. Section 59A-7-11 NMSA 1978;
- 11 G. Chapter 59A, Article 8 NMSA 1978;
- 12 H. Chapter 59A, Article 10 NMSA 1978;
- 13 I. Section 59A-12-22 NMSA 1978;
- 14 J. Chapter 59A, Article 16 NMSA 1978;
- 15 K. Chapter 59A, Article 18 NMSA 1978;
- 16 [~~L. Chapter 59A, Article 19 NMSA 1978;~~]
- 17 ~~M. Section 59A-22-2.1 NMSA 1978;~~
- 18 ~~N.] L. The Policy Language Simplification Law;~~
- 19 M. Subsections B through E of Section 59A-22-5 NMSA  
20 1978;
- 21 [~~0.] N. Section 59A-22-14 NMSA 1978;~~
- 22 [~~P.] 0. Section 59A-22-34.1 NMSA 1978;~~
- 23 [~~Q.] P. Section 59A-22-39 NMSA 1978;~~
- 24 [~~R.] Q. Section 59A-22-40 NMSA 1978;~~
- 25 [~~S.] R. Section 59A-22-41 NMSA 1978;~~

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S. Section 59A-22-42 NMSA 1978;

T. Section 59A-22-44 NMSA 1978;

~~[F.]~~ U. Sections 59A-34-7 through 59A-34-13, 59A-34-17, 59A-34-23, 59A-34-33, 59A-34-40 through 59A-34-42 and 59A-34-44 through 59A-34-46 NMSA 1978;

~~[U. Chapter 59A, Article 37 NMSA 1978]~~ V. The Insurance Holding Company Law, except Section 59A-37-7 NMSA 1978;

~~[V.]~~ W. Section 59A-46-15 NMSA 1978; and

~~[W.]~~ X. the Patient Protection Act. "

Section 6. [NEW MATERIAL] SUPERINTENDENT OF INSURANCE--  
ADDITIONAL POWERS.--The superintendent of insurance shall promulgate rules to define minimum coverage for smoking prevention and cessation treatment.

Section 7. APPLICABILITY.--The provisions of this act apply to policies, plans, contracts and certificates delivered or issued for delivery or renewed, extended or amended pursuant to the New Mexico Insurance Code in this state on or after July 1, 2003.